North Carolina
Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center - Raleigh, N.C. 27699-2501
Michael F. Easley, Governor
Secretary Carmen Hooker Odom, Secretary
Allen Dobson, Jr., M.D., Assistant
for Health Policy and Medical Assistance

NON-COVERED STATE MEDICAID PLAN SERVICES FOR RECIPIENTS UNDER AGE 21

The Social Security Act (the Act) at (1905)(a) requires state Medicaid agencies to provide early and periodic screening, diagnostic, and treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT, states are to cover any service that is medically necessary "to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening", whether or not the service is covered under the North Carolina State Medicaid Plan. The services required to be provided under EPSDT are limited to services within the scope of services listed in the Act at 1905(a). See listing of services on the following page. State Medicaid agencies are not required to provide any service, product, or procedure that it determines to be unsafe, ineffective, or experimental.

MAKING A REQUEST FOR A NON-COVERED STATE MEDICAID PLAN SERVICE

To make a request for a service that the North Carolina State Medicaid Plan does not cover for recipients under 21 years of age, a physician or other licensed clinician must submit a Non-covered State Medicaid Plan Services Request form to the Division of Medical Assistance (DMA) **prior** to performing the service. The completed form may be submitted by either facsimile (fax) or mail as indicated on the form. For questions about the process to request a non-covered state Medicaid Plan service, physicians and other licensed clinicians should review the Medicaid Special Bulletin published January 2006, entitled "Prior Approval Process and Request for Non-Covered Services", and located on the DMA website at http://www.dhhs.state.nc.us/dma/bulletin/0105bulletin.pdf. Recipients should review the "Medicaid Consumer's Guide to North Carolina Medicaid Health Insurance for Families and Children" given to them at the time of Medicaid application and available on DMA's website at http://www.dhhs.state.nc.us/dma/consinfo.htm. Additionally, recipients may call the CARE-LINE Information and Referral Service Monday-Friday, except state holidays, at the numbers specified below.

INSIDE TRIANGLE AREA	OUTSIDE TRIANGLE AREA
919-855-4400 (English/Spanish)	1-800-662-7030 (English/Spanish)
919-733-4851 (TTY # for deaf/hearing impaired)	1-877-452-2514 (TTY # for deaf/hearing impaired)

REVIEWING A REQUEST FOR A NON-COVERED STATE MEDICAID PLAN SERVICE

If the request is approved, Medicaid will notify the provider. If the request cannot be approved based upon the information submitted, Medicaid must deny the request. Both the recipient and the provider will receive written notification of the decision. The denial notice will also explain how the decision may be appealed. **Only** the recipient or the legal representative may appeal the decision. Should Medicaid be unable to make a decision to approve or deny the request because insufficient information was submitted, Medicaid will notify the provider and recipient in writing that the request lacks necessary documentation to approve or deny the request. The provider must submit additional documentation as specified by the notice, usually 15 business days. Medicaid recognizes that there may be situations where 15 business days may not allow sufficient time for a response. Medicaid will extend the deadline to a mutually agreed upon response date **as long as** the provider telephones or writes Medicaid to request additional time to respond by the deadline date specified in the notice. If there is no response from the provider by the date specified in the notice or if the provider does not submit the additional information by the agreed upon date, the recipient and the provider will be notified in writing that the request is denied for insufficient information. As indicated above, the denial notice will also explain how the **recipient or legal representative** may appeal the decision, if desired.

MAKING A SECOND REQUEST FOR A DENIED NON-COVERED STATE MEDICAID PLAN SERVICE

If a request for service was denied because additional information was not received, a new request may be made **at any time**. The provider should submit a new request for the non-covered state Medicaid Plan service previously denied along with the needed documentation to support that the service is medically necessary "to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening". The request will be reviewed anew. **OVER**

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NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM FOR RECIPIENTS *UNDER* 21 YEARS OF AGE

RECIPIENT INFORMATION: ***Must be completed by physician, licensed clinician, or provider.***

NAME:_____

DATE OF BIRTH:____/____/_____*(mm/dd/yyyy)* **MEDICAID NUMBER:**_____

ADDRESS: _____

_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, including CPT and HCPCS codes as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME:_____ **PROVIDER NAME:**_____

MEDICAID PROVIDER #:_____ **MEDICAID PROVIDER #:**_____

ADDRESS:_____ **ADDRESS:**_____

_____ _____

TELEPHONE #: (___)_____ **TELEPHONE #: (___)**_____

FAX #:_____ **FAX #:**_____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT ***(incl. length of time you have cared for recipient and nature of the care)*****:**_____

_____

_____

PAST HEALTH HISTORY ***(incl. chronic illness)*****:**_____

_____

_____

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE. (*MUST* *incl. applicable CPT AND HCPCS codes).* PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL AND MENTAL ILLNESS OR CONDITION. _____

_____

_____

_____

_____

11/05
REV. 07/06

NAME:	MID #:	DOB:

RECIPIENT DIAGNOSIS(ES) RELATED TO THIS REQUEST ***(incl. onset, course of the disease, and recipient's current status)*****:**_____
_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE ***(incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)*****:**_____
_____
_____
_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:
___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____
_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE: ___YES ___NO IF NO, PLEASE EXPLAIN._____
_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:
___YES ___NO IF NO, PLEASE EXPLAIN._____
_____

ARE THERE ALTERNATIVE TREATMENTS THAT COULD BE TRIED: ___YES ___NO
IF NO, SPECIFY WHY ALTERNATIVES ARE INAPPROPRIATE AND PROVIDE EVIDENCE BASE WITH THIS REQUEST.
_____
_____
_____
_____

WHAT IS THE EXPECTED DURATION OF TREATMENT:_____

WHAT ARE THE EXPECTED TREATMENT OUTCOMES RELATED TO THIS REQUEST:
_____
_____

ADDITIONAL INFORMATION MUST BE SUBMITTED ON PROVIDER'S LETTERHEAD AND SIGNED BY THE PHYSICIAN OR LICENSED CLINICIAN MAKING REQUEST.

_____ _____
REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

MAIL OR FAX COMPLETED FORM TO:
Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

MEDICAID COVERED SERVICES
SOCIAL SECURITY ACT AT 1905(a)

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services, including nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services
- Private duty nursing services (in the recipient's private residence)
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
- Services in an intermediate care facility for the mentally retarded
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services
- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation)